Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVITALIZING THE COMMUNITY HEALTH REPRESENTATIVE PROGRAM

APRIL 1993

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APRIL 1993 OEI-05-91-01070

EXECUTIVE SUMMARY

PURPOSE

This report describes factors which make Community Health Representative (CHR) programs effective. The Public Health Service (PHS) could use these factors to revitalize the program.

BACKGROUND

The CHR program is based on the concept that indigenous community members, trained in the basic skills of health care provision, disease control, and prevention, can successfully effect change in community acceptance and utilization of health care resources. The CHR program is governed by the Indian Health Care Improvement Act of 1988. In Fiscal Year (FY) 1992, the Indian Health Service (IHS), within PHS, spent $39 million for 1,544 CHRs in 260 programs. The program is funded through contracts, grants, or cooperative agreements based on the Indian Self-Determination and Education Assistant Act (P.L. 93-638), hereafter referred to as 638.

In 1983, Congress mandated that IHS establish guidelines, goals, and clear evaluation standards for the CHR program. The IHS produced guidelines and goals for the program which are written in Chapter 16 of the Indian Health Manual. They also developed two management tools: the Scope of Work (SOW), for planning purposes, and the CHR Information System II (CHRIS II), for reporting.

Although Chapter 16 states that tribal CHR programs will be evaluated on a triennial basis, IHS has neither developed evaluation criteria nor conducted a national evaluation of the program.

SCOPE AND METHODOLOGY

This report should be read along with our companion report entitled "Management Issues in the CHR Program." In that report, we recommended that PHS, and tribes, thoroughly re-examine the CHR program and decide whether to retain it in its current form, revise it to become a transport program, or abolish it. Should they retain the program, we recommended that they develop a national strategy to revitalize it.

This report presents information which could be useful to PHS in developing a revitalization strategy. It describes what 403 respondents - from the national, area, and local levels - said were the most important factors that make individual CHR programs effective, and why they make programs effective. It also describes how the factors can be used to judge the effectiveness of a CHR program.

FINDINGS

According to respondents, four factors make CHR programs effective.

Factor 1: Agreement on the Role of the CHR

Area and local respondents ranked this factor number one. Their view is that the role of the CHRs at a program must be well defined and understood by everyone involved before any of the other factors can have any impact on the effectiveness of the program.

Factor 2: Integration into the Health Care System

A majority of the CHRs ranked this as the factor with the greatest influence on the effectiveness of their program. Other respondents all spoke of the need for CHRs to work closely with health care professionals, especially if they provide medical care to patients. They also said that this is important in the CHRs' role as link to the community.

Factor 3: Tribal Support and Direction

Respondents say that a lack of tribal support and direction may cause a CHR program to deteriorate. It may also lower the morale of the CHRs.

Factor 4: IHS Support and Direction

Respondents believe IHS support has less impact on the effectiveness of CHR programs than other factors. However, they also say that IHS support is needed to make programs strong.

CONCLUSION

When we applied these factors at two CHR programs, using a case study approach, we found that they were useful in judging the effectiveness of the programs. If PHS decides to revitalize the CHR program, we encourage them to consider these factors in developing a multi-faced national strategy for doing so.

COMMENTS

The Assistant Secretary for Planning and Evaluation (ASPE) and PHS commented on the report. The ASPE agreed that more attention should be paid to the CHR program. The PHS described steps that IHS has initiated to revitalize the CHR program, noting that their revitalization strategy will take into account the factors described in this report. The full text of the comments is in Appendix B.

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INTRODUCTION

PURPOSE

We conducted this study to identify and assess factors which make Community Health Representative (CHR) programs effective. The Public Health Service (PHS) could use these factors to revitalize the program.

BACKGROUND

Program History

In 1968, under the 1921 Snyder Act (25 U.S.C. 13), Congress established the CHR program within the Indian Health Service (IHS) in PHS. The program was intended to provide outreach health care services for American Indian and Alaska Native tribal governments and organizations. It is based on the concept that indigenous community members, trained in the basic skills of health care provision, disease control, and prevention, can successfully effect change in community acceptance and utilization of health care resources. A CHR is "a tribal or Native community-based, well-trained, medically-guided, health care provider, who may include traditional Native concepts in his/her work."[1]

The program is currently governed by the Indian Health Care Improvement Act Amendments of 1988. In Fiscal Year (FY) 1992, IHS spent $39 million for 1,544 CHRs in 260 programs throughout the continental United States and Alaska. Currently, IHS spends about $1 million of this amount on training for CHRs, including funding a national training officer and a number of training facilities.

The CHR program is funded through contracts, grants or cooperative agreement arrangements with Native or tribal governments and organizations based on the Indian Self-Determination and Education Assistance Act (P.L. 93-638), hereafter referred to as 638. The IHS is increasingly using 638 contracts as a mechanism to provide health services to Indian people. Under them, tribes are delegated responsibility for administering programs, and have great latitude in designing and operating them. The IHS sets basic parameters and guidelines, and is responsible for management and oversight of the national CHR program; however in terms of the day-to-day operation of individual programs, IHS assumes more of a consultation and technical assistance role.

The program grew quickly from 1968 to 1980. At that time, however, Congress grew concerned that the budget for the program could not be adequately justified. Program activities had not been clearly documented and monitored by IHS, and programs varied widely across tribes. Congress grew concerned about a lack of program goals and objectives and an adequate reporting system, and reports that the CHR program was little more than a "jobs" or employment program for reservations. In FY 1981 and 1982, Congress began to reduce the number of CHR positions, and in FY 1983 the program

came close to being eliminated. Although the program ultimately survived, Congress cut 513 slots from a peak of 2,293. This decline continued until FY 1990, when Congress slowly began to increase slots to the 1,544 of today.

Program Administration

In 1983, Congress mandated that IHS establish guidelines, goals, and clear evaluation standards for the CHR program. In response, IHS established the position of a national CHR program director and developed program goals, objectives and guidelines which are written in Chapter 16 of the Indian Health Manual.

Individual CHR contracts are administered by the 12 IHS area offices. The national CHR program director, in the Office of Health Programs under the Special Initiatives Branch, has no direct line authority over these area offices or staff. In more of a consultation or technical assistance role, that office develops and implements management standards and tools, plans training, and conducts program reviews.

In each area office, a CHR coordinator is the primary contact with the national program director and the one area staff person with direct responsibility for CHR programs. Project officers also have certain program and fiscal responsibilities in connection with monitoring contracts, including CHR contracts, and facilitating the interaction between tribal CHR programs and the service unit or area health care programs. Most CHR coordinators and project officers juggle CHR duties with other responsibilities.

The IHS uses two important management tools in the CHR program. The Scope of Work (SOW) is a form tribes may use to plan their CHR programs. The CHR Information System II, or CHRIS II, is a reporting system based on the SOW. Although not required to use either the SOW and CHRIS II, at present most of the tribes are doing so.

Chapter 16 states, "Tribal programs will be evaluated on a triennial basis, through the use of a nationally developed instrument, with tribal consultation and concurrence."[2] To date, however, IHS has neither developed evaluation criteria or tools nor conducted a national evaluation of the program.

SCOPE AND METHODOLOGY

The intent of this study was to identify and assess factors that make CHR programs effective. This report describes those factors. A companion report entitled "Management Issues in the CHR Program" (OEI-05-91-01071) describes certain management issues that arose in the course of the study.

As background for the study, we conducted a review of literature: legislation and regulations on the CHR program, the Indian Self Determination Act, and the Indian Health Care Improvement Act; Chapter 16 of the IHS manual; annual reports, CHRIS II reports and other documents related to the CHR program; and reports on Indian health.

We also spoke with persons in the Office of Management and Budget, and the Office of the Assistant Secretary for Planning and Evaluation in the Department of Health and Human Services.

Data collection took place in three phases. As this chart shows, we contacted over 400 respondents for the study.

Respondents	Phase 1	Phase 2	Phase 3	Total
National	6	23		29
Area	22	30	10	62
Local	16	58	25	99
CHRs	32	161	20	213
Total	76	272	55	403

Phase One: In November and December 1991, we visited 2 of the 12 IHS area offices and 5 CHR programs, chosen in collaboration with IHS Area coordinators to represent a variety of types of programs. We talked with over 75 respondents: people involved in creating the program; IHS staff in area offices; and people in CHR programs and service units. We also held focus groups with area CHR coordinators and CHRs and talked to the national training officer and persons from the National Association of CHRs. We asked them "What makes a CHR program strong (effective)?" They identified four broad factors that make programs effective. In Phases Two and Three of the study, we set out to learn more about the factors and assess their usefulness in judging program effectiveness in a "real life" situation.

Phase Two: In February, March, and April 1992, we contacted an additional 272 respondents to learn their perceptions about the factors: how important are they, and why?; if a factor is not present in a CHR program, is the program weakened?; and, what can IHS do to strengthen or promote these factors?

- At the national level, we talked to Congressional staff, people in the Office of the Assistant Secretary for Health in PHS, and IHS Headquarters staff.

- At the area level, we chose five IHS area offices (Oklahoma City, Oklahoma; Aberdeen, South Dakota; Window Rock, Arizona, Navajo Nation; Portland, Oregon; and Nashville, Tennessee) which are diverse in terms of geography, program sizes and types, and together represent half of the 1,544 CHRs nationwide. We talked to area directors, CHR coordinators, and other health care professionals in these offices.

- For respondents at the local, or program, level, we chose three CHR programs in each of these five areas (15 total). They were programs that had more than two CHRs, represented a geographic and programmatic mix, and agreed to participate in the study. We spoke by telephone with the tribal health directors, CHR supervisors, service unit directors, and health care professionals at these programs. We also contacted 161 CHRs. One of the 15 tribal officials we contacted responded to our inquiries.

- We visited a third IHS area office and three other CHR programs in connection with a review conducted by the national CHR program director. We also talked to tribal health directors at a conference.

Phase Three: In April 1992, using a case study approach, we visited two CHR programs in two IHS areas, to apply these factors in a "real life" situation. We chose the programs in collaboration with the national program director, the CHR coordinator in each area, and the tribes themselves. Each program had 10 CHRs, most of them working as generalists although some positions were dedicated to clerical or data entry work. The sites were rural. Both had IHS service units. We contacted 55 respondents in this phase.

This study was conducted in accordance with the Interim Standards for Inspections issued by the President's Council on Integrity and Efficiency.

FINDINGS

INTRODUCTION

In our report entitled "Management Issues in the CHR Program," we recommended that PHS, and tribes, undertake a thorough re-examination of the CHR program and decide whether to retain the program in its current form, revise it to become a transport program, or abolish it. Should they opt to retain the program, we recommended that they develop a strategy to revitalize it.

This report describes what the 403 respondents in this study - from the national, area, and local levels - said were the four most important factors that make individual CHR programs effective. Should PHS decide to revitalize the CHR program, these four factors should be considered in the development of a strategy to do so.

The factors are:

Factors that Influence the Effectiveness of CHR Programs

Factor 1 Agreement on the role of the CHR
Factor 2 Integration into the health care system
Factor 3 Tribal support and direction
Factor 4 IHS support and direction

We describe why respondents think the factors make programs effective, and what specific building blocks, or "elements," comprise each one. We also explain how the factors and elements can be used to judge the effectiveness of a CHR program. We discuss each factor in the following format, and then present our conclusions.

Importance of the Factor: Why respondents think the factor makes CHR programs strong, and what impact its presence or absence has on a program's effectiveness.

Elements for the Factor: What respondents said comprises the factor.

Case Study Analysis: How we applied the factor and its elements in two CHR programs, and what we learned about the programs using them.

FACTOR 1: AGREEMENT ON THE ROLE OF THE CHR

Importance of Factor

Local and area respondents think that there must be agreement on the role of the CHR at a program before any of the other factors can impact the program.

In terms of its influence on the effectiveness of CHR programs, local and area respondents ranked "Agreement on the Role of the CHR" number one in importance among the four factors. Their view is that the role of the CHRs at a program must be well defined and understood by everyone involved before any of the other factors can have any impact on the effectiveness of the program. They say that if tribal officials, health directors, medical staff and CHRs do not have consensus about the CHR role, services will become "fragmented and chaotic." Also, CHRs would operate on an ad hoc basis with each going their own way, like, as one respondent described, "a covey of quails."

The CHRs ranked this factor third in importance. Numerous CHRs commented on the need for more focused direction and supervision; some complained that they had "too many bosses."

The IHS headquarters respondents believe that once there is consensus on the role, programs will have greater stability if the community, health care staff, and tribal officials have the same expectations for the program. They were particularly concerned about how a lack of agreement affects CHR morale. They are troubled that CHRs are "perceived as the answer to everyone's problems." They said that CHRs are often pulled in different directions between what they think they should do and tribal members who might ask them to do inappropriate things: non-health-related things not in the SOW such as delivering groceries or commodities, chopping wood, janitorial services or transporting people to non-health-related functions.

Elements

Respondents suggested the following elements to identify whether there is agreement on the role of the CHR at a given program.

A. Are there written goals, objectives, policies, procedures, job descriptions, a tribal health plan, and a written transportation policy? Have they been implemented?

B. Do tribal leaders, community members, health program administrators and CHRs understand the CHR role? Do they all have the same understanding of the role?

C. What kinds of requests for service do CHRs get from the community and medical staff? Are the requests within the range of services agreed on for CHRs?

D. Are CHRIS II and SOW reports available? Do they show that CHRs are providing intended services?

E. Do CHRs work closely with the tribe's health care system? Is there: continuity of care, coordinated effort, good communication, and teamwork?

F. Are there many consumer complaints? Are consumers satisfied with the CHR program?

Case Study Analysis

The elements told us that there is agreement on the role of the CHR in the two case study programs. They also told us that this agreed-upon role is to provide transportation. The elements were easy to apply, but observation was key to accurately assessing the programs.

A. With the notable exception of a tribal health plan, we had little difficulty obtaining written policies, procedures, goals, objectives and reports at either site. Both sites were rich in such documentation. However, we found that simply reviewing these documents was inadequate; only observation enabled us to learn what was really happening in these programs.

The CHR position descriptions we found at both programs provide one example of how written documents can be misleading. They were very broad and included services such as referral/liaison, direct health services, health education, and counseling. Transportation was included, but not emphasized. Yet in both programs, we observed that CHRs were heavily involved in transportation. Observation thus gave us a very different - a more "real" - picture of what CHRs were actually doing, as opposed to what the position descriptions said they were doing.

Both programs had some kind of transportation policy that set limitations on CHR transportation services. However, we could not tell how strictly the policies were enforced.

At one site, the most revealing written documents were the monthly and quarterly reports produced by the program manager summarizing CHR activities for the time period. Transportation activities clearly dominate. The reports also mentioned other activities such as delivering medication and commodities, and assisting families at funerals.

B. At both sites we talked to people about their view of the CHR role. Most of them talked about transportation services. Tribal officials, medical staff, community members, and the CHRs were very supportive of this function. Only a few people brought up the notion of CHRs doing other types of activities, like home care and personal care services. At one site we talked to a tribal official who stressed the importance of transportation, but seemed open to an expanded

role for CHRs and was interested in hearing about what other tribes do with their CHR programs.

C. Community members, medical staff, and tribal officials request services from the CHRs at these programs. The CHR supervisor schedules requests that are made in advance, but CHRs also spend time responding to immediate needs. At both sites, the primary requests were for transportation and delivery services. We learned about requests for service by observing CHRs in their daily activities, and by reviewing some of their daily activity logs.

D. Both programs use the SOW and CHRIS II, and they provided us with their latest reports. We compared the CHRIS II reports to the SOW to see if CHRs were carrying out planned activities. We generally found the two documents to be comparable. However, at one program, we were troubled that the reports did not reflect our own observation of the services being provided. The SOW and CHRIS II showed transport services to be 15 percent and 22 percent of total CHR time respectively. Yet our impression was that transport is the primary if not the only activity of the CHRs in those programs. This example accentuates the point that written documents and reports should not be relied on exclusively to gauge program performance.

E. We were able to assess the degree of interaction between the CHR program and the other health programs through interviews with CHRs and health care staff. We asked about the relationship between the programs. At both sites respondents told us that the primary purpose for interaction was for CHRs to provide transportation. We discuss this further in the next section: "Integration with the Health Care System."

F. The element that we found most difficult to apply was "consumer satisfaction." As people who spent only a few days with each program, we found it difficult to learn key community perspectives about the CHR program in any depth. A few times we heard complaints or hints of dissatisfaction. Generally, though, community members expressed satisfaction with programs and were grateful for the services they have received from CHRs.

In summary, these elements told us that there is strong agreement on the role of the CHR in both programs. That agreed-upon role is primarily one of transporting patients to and from medical appointments, and delivering medications.

We were able to apply all of the elements related to agreement on the role of the CHR, although some were easier to apply than others. Furthermore, we found that some elements could be misleading, and that observation is key to getting a full and accurate picture of a program. For example, CHRIS II reports and CHR position descriptions portrayed CHRs as involved in a wide variety of activities, yet we observed that these programs were concentrated on providing transportation. We learned also that the

absence of documents (like a tribal health plan) can tell us about program priorities, interests, and goals - or the lack thereof.

FACTOR 2: INTEGRATION INTO THE HEALTH CARE SYSTEM

Importance of Factor

A majority of the CHRs ranked Integration into the Health Care System as the factor with the greatest influence on the effectiveness of their program.

Fifty-eight percent of the CHRs ranked "Integration" the number one factor that influences CHR program effectiveness. In addition, 71 percent of the area and local respondents believe that a CHR program will be weakened "greatly" if integration does not occur.

Respondents from the local, area, and national levels all spoke of the need for CHRs to work closely with health care professionals, especially if CHRs provide medical care to patients. They also said this is important in the CHRs' role as the "link" to the community.

A CHR program that lacks integration with the rest of the health care system could be affected in a variety of ways. Some respondents said that duplication and gaps in services would occur, and that health care professionals might lose their link to the community. Other respondents were concerned that without interaction with a health care professional, a CHR might make a mistake or provide misinformation in the course of providing health services. Still others voiced that CHRs might provide services that are not even related to health, such as janitorial or clerical.

Elements

Respondents suggested the following types of elements to identify whether a CHR program is integrated with the tribe's health care system.

A. Are there referrals between CHR programs and other health care programs? What are the types of referrals? What services are provided as a result of referrals?

B. Do health care professionals know, respect, and support CHR programs?

C. Do CHRs participate in meetings and committees with health care professionals?

D. Are CHR activities closely related to defined community health needs? Is there a tribal health plan?

E. Is CHR training planned/coordinated with training of health care professionals?

F. Do CHRs document their services for patients in patient medical records?[3]

G. Does the CHR position description specify interaction with health care professionals?

H. Does the CHR manager/supervisor have a health care background?

I. Is integration specified in the tribe's contract with IHS?

Case Study Analysis

The elements for "Integration" were easy to apply. They provided very strong evidence that neither program is well integrated with other health care programs, and that CHRs are not involved in providing health care services.

A. We asked about the referral system at both sites. At one site, referrals were numerous and most were for transportation. Referrals in the other program could not be tracked, both in terms of the number of referrals or the kind of service provided as a result of referrals.

We also looked at reports for evidence of referrals. At one program we found the reports unreliable. For example in 1991, the CHRIS II report counts 857 referrals, but the tribe's annual report claims a total of 151.

B. Discussions with health care professionals revealed that they saw the CHRs solely as transporters. At one site the CHR program is co-located with another health program and supervised by the same person. There did appear to be some interaction and referral between the two programs, but it was ad hoc and primarily for transportation services. At the same time, a conflict between the CHR program manager and another department head stood in the way of those two programs working together.

At the other site, although the CHRs transport many diabetic patients to and from the clinic, the diabetes counselor did not know that CHRs had any knowledge or training about diabetes, including nutrition and foot checks. If the CHRs have any valuable information about patients and their home life, we saw nothing to indicate that it is being utilized by health care professionals.

C. The CHRs at both programs we visited did not meet at all with other health care professionals. We did hear that one of the CHR supervisors is invited to health promotion/disease prevention committee meetings but does not attend.

D. We looked for a tribal health plan to determine whether CHRs are included in tribal plans to provide health-related services (as opposed to strictly transport). We found no such plan, nor in either setting did we see a any other plan specifically tying CHR activities in to defined community health needs.

E. Training of CHRs was not coordinated with health care professionals. The day we visited one site, many of the service unit health care professionals were attending an all-day seminar at the service unit. The CHRs were not invited, nor, we learned, was it conceivable to the health care professionals that CHRs would ever be invited to such training.

F. None of the other elements suggested by respondents was present at these two programs. CHR activities were not documented in patient medical records, we saw no instances where CHR position descriptions specified integration, managers/supervisors did not appear to have health care backgrounds, and integration was not specified in IHS contracts for these CHR programs.

Together these elements provided strong evidence that these CHR programs were not well integrated with other health programs, particularly with those at the service unit. Health care professionals and CHR program administrators saw "integration" solely in terms of referrals to CHRs for transportation services or delivering medications.

We found the elements on health professionals' opinions about the CHR program (B) and referrals (A) particularly useful for assessing this factor. However, in terms of referrals, we agreed with respondents who said that we should go beyond simply counting the number of referrals between departments to get an accurate picture of the extent or quality of integration. It is also important to know what types of referrals are being made, and the outcome. For example, if referrals are solely for transportation, that tells us that CHRs may not be working to provide health care services alongside health care professionals.

FACTOR 3: TRIBAL SUPPORT AND DIRECTION

Importance of Factor

Respondents say that a lack of tribal support and direction jeopardizes the effectiveness of a CHR program and lowers CHR morale.

Respondents at IHS headquarters ranked "Tribal Support and Direction" as the number one influence on program effectiveness. They think that tribal officials and community members should understand and support the role of the CHR.

The CHRs ranked tribal support and direction second in importance. They had strong opinions about some of the elements for this factor. For example, seventy-eight percent feel that CHR employment decisions and CHR daily activities should not be influenced by tribal politics.

The view of local and area respondents was that the CHR program would deteriorate without support from the tribe. Like CHRs, these respondents were concerned that CHR programs are vulnerable to becoming "political footballs." They said that tribal leadership can change frequently, often impacting hiring and firing decisions with each

new administration. Also, they noted that both pressure on CHRs by tribal officials to respond to inappropriate requests, and community complaints, may serve to lower CHR morale.

Elements

Respondents suggested the following types of elements to identify the degree of tribal support and direction in a CHR program.

A. Does the program have strong management and supervision?

B. Is the CHR program insulated from tribal politics? Does the tribe support the program by providing: resolutions or letters of support, CHR access to tribal leadership, and/or a formal system for resolving complaints from the community?

C. What is the level of satisfaction with the program on the part of tribal officials, community members, and CHRs themselves?

D. Do tribes make adequate equipment and materials available to the CHR program (e.g. office space/supplies, adequate travel reimbursement, training, and salaries)?

E. Does the tribe see the CHR program as part of the health care system? In an organizational chart, where is the CHR program located in relation to other health care programs? Is there a tribal health plan?

Case Study Analysis

We found tribal support to be the most difficult factor to assess. Some elements include sensitive or hard-to-obtain information.

A. To assess management and supervision, we asked to see managerial tools such as activity logs, reports, and schedules. Next, we talked to the CHR supervisors about their day-to-day operations and how the CHRs are monitored. We found that both programs had management systems in place and were reasonably well organized and supervised.

   In relation to strong management, respondents also noted the importance of having a strong CHR supervisor, who could compensate for a lack of involvement or support by the tribe. Based on our observations, we agree that this position could play an important role in focusing and improving these two programs. The supervisors at both appeared to have little health care background or training in managing a health care program. We believe that this may partially explain why the programs have not established a role in the health care system beyond transportation.

B. One of the more difficult elements for us to assess was the impact of tribal politics on these CHR programs. We found that the only way to learn about the political environment was from people in the program and the community. Therefore, much of our evidence about tribal politics is anecdotal.

For example, a manager at one program complained that the tribal chief or the tribal health administrator could call at "the drop of a hat" for a CHR to pick someone up. Also, one tribal official told us that there were sometimes complaints that CHRs serve mainly their own relatives. However, we could not verify these stories. As another illustration of how tribal politics can affect a program, at one site hiring decisions about CHRs are made by the tribal council rather than the program manager, who can only "suggest" possible candidates.

We found no official recognition from the tribe in either program in the form of resolutions or letters of support, commendations, certificates or honors for the CHRs. While the IHS area office provides some of these things, we found no evidence that the tribes do.

C. As we have mentioned under Factor 1, it was difficult to gauge community opinion about the CHR program. When asked about the program, tribal officials and community members spoke quite favorably; they believe that the services provided by the CHRs are very important. Our conclusion, however, is that their support is very much based on the programs' status quo, i.e. transportation. Beyond verbally supporting the programs, these tribes appeared to be minimally involved with them. In fact we were struck by the lack of knowledge, beyond transportation, about the program on the part of most tribal officials we talked to.

On the surface, CHRs appeared to be satisfied with their programs and leadership, though it is difficult for us to say after only a few days. At one site, a few CHRs spoke of some dissatisfaction with tribal administration.

D. Respondents, particularly CHRs, suggested we look at the types of resources that tribes provide for the CHR program to gauge the level of tribal support. In terms of transportation, one program provides cars for their CHRs, and at the other site, CHRs use their personal vehicles. At these two sites (as well as the eight others we visited for this study), CHRs complained about the low level of reimbursement for travel, and low salaries. At one program, CHRs said they had not received any pay increases in the past 10 years, while they watched staff in other tribal health programs receive various raises and bonuses.

E. As for Factors 1 and 2, respondents suggested we look for evidence that health is a priority for the tribe (i.e. studies, health plans, needs assessments, etc.) as an element of tribal support and direction. As stated earlier, these two programs lacked this element. The fact that this element appears for Factors 1, 2, and 3 points both to its importance and to the interrelatedness of the factors and elements.

Based on these elements, our conclusion is that there is tribal support for these two programs, but that it is based on their being transportation programs. Beyond supporting a transportation role for their CHRs, the tribes showed little interest or active involvement in the programs. There were no written documents voicing support, no health plans, and little discernible interest in expanding the CHR role to encompass health care services.

We had some difficulty assessing this factor. Although we heard that tribes supported the CHR programs, we found no written forms of support or evidence of it, including evidence that health is even a priority for these tribes. Also, while CHRs as a group seemed satisfied, some of them individually expressed concerns about political influence on their program.

We did not have enough time to delve sufficiently into this conflicting information. Furthermore, lacking a historical perspective, it was difficult for us to gauge what impact tribal politics might have on these programs. We believe that someone in closer contact with a tribe, such as the area CHR coordinator, might find it easier to apply these particular elements.

FACTOR 4: IHS SUPPORT AND DIRECTION

Importance of Factor

Respondents believe that while IHS support has less impact on the effectiveness of CHR programs than other factors, it is important to make programs strong.

The CHRs ranked this element third in importance of the four factors. Area and local respondents ranked it fourth. Even so, they still believe that IHS can strengthen programs. For example, one said that, without IHS support, a CHR program "would be a rudderless ship . . . (CHRs) might be busy, but they won't be effective."

Elements

Respondents identified the following elements as ways to gauge IHS support and direction for a CHR program.

A. Is there a positive relationship between IHS and the tribe? Is IHS responsive to requests? Is there on-going communication between the CHR program and IHS area and local staff?

B. Does the IHS area office have a full-time CHR coordinator, with an appropriate background and support?

C. Does IHS provide adequate funding, equipment, materials, and training to the program?

D. Does IHS provide technical assistance to tribes on how to use the various management tools - especially the SOW and CHRIS II?

E. Is the IHS service unit at the program providing regular and useful technical assistance, management, and professional assistance?

F. Does IHS monitor and review the program, i.e. conduct audits, evaluations, and site visits?

Case Study Analysis

The elements told us that IHS provides administrative and financial support for these CHR programs but does not actively promote or encourage tribes to involve their CHRs in the health care system beyond a transport role.

A. To learn about the relationship between IHS and the two tribes, we talked to both tribal and IHS staff. At one program, the IHS area office clearly had a close relationship with the CHR program. Staff there were verbally supportive of the program and felt it was one of the best in the area. This area office has provided significant extra funding for this program, including funds for cash bonuses for the CHRs. The CHR coordinator makes periodic visits and makes training available to the program.
The relationship was more difficult to assess at the other site. The IHS project officer and service unit director told us that they work very closely with the tribe. However, the CHR coordinator was new and not yet familiar with the program. We got a different perception about the degree of IHS support from some people at the tribal level.

B. One of the CHR coordinators is full-time, the other has multiple responsibilities in addition to the CHR program. This is common in the CHR program as a whole; only 2 of the 12 area CHR coordinators are full-time.

C. Funding and resources appear to be adequate for the programs we visited. However, we frequently heard complaints from CHRs about low salaries. (Even though salaries are set by the tribes, many people seem to expect IHS to be responsible for salary increases.) People also talked of a need for better travel reimbursement or more government cars.

In terms of training, IHS provides the basic training course to all CHRs but availability of other training varies from program to program. At one program, IHS rather than the tribe makes training available; CHRs are encouraged to attend training and other regional conferences. At the other site, we saw that until recently, CHRs had not received any training from IHS, nationally or at the service unit level.

D. The area CHR coordinators do provide technical assistance to tribes on how to fill out the SOW and the CHRIS II reports, and stress the importance of reporting CHR activities. However we do not know how much they focus on their use as management tools. For example, while the CHR coordinator for one program expressed concern about the incongruence of transportation services listed on the SOW and CHRIS II reports, the thought was more that the SOW needed to be updated to match the latest CHRIS II report, rather than reorienting CHR activities to conform to the SOW.

We did not get the impression that programs use the SOW and CHRIS II for management purposes. Rather, administrators largely viewed CHRIS II reports as necessary ways to get funding for their programs. The supervisor at one program said she planned to use the SOW and CHRIS II for management purposes, however this program, like the other, still remained focused primarily on transportation.

E. We saw little effort on the part of IHS service unit staff to offer these programs the guidance needed to change or expand them into health service areas beyond than transportation. To the contrary, service unit medical staff relied on CHRs for transportation. In addition, neither service unit provided any training to the CHRs.

F. The two CHR coordinators monitor their programs primarily by phone, with occasional site visits. The project officers also monitor the programs in terms of contractual issues and problems. However, IHS staff did not appear to formally audit or evaluate these programs on a regular basis. We did not hear of any fiscal review of these programs by the program officers. And we learned that required audits cover a tribe's entire contract rather than one program alone.

At one program, we learned that, a few years ago, an internal control review by the area office had recommended that a formal link be established between the CHR and public health nursing programs. However the recommendation was never acted upon, and was eventually quietly dropped.

Although we found that we could apply these elements in a program, in our view their usefulness is somewhat limited. We found that they can be present in a program, yet not have a significant impact on making the program effective in meeting health care needs. For example, neither the nature of the relationship between the tribe and the CHR coordinator, nor whether the coordinator was full- or part-time, seemed to affect the outcome of the programs; they both remained heavily focused on transportation.

The more important issue seems to be the focus of support that IHS gives these programs. That is, we noticed that IHS emphasis seems to be on administrative issues (like reporting and budget), and perpetuates the status quo of transport rather than help the programs expand beyond it.

For this reason, we suggest that another element be added for this factor:

G. IHS area and service unit staff actively encourage and assist tribes to incorporate in their CHR programs: (1) agreement on the role of the CHR, (2) integration into the health care system, and (3) strong tribal support and direction.

CONCLUSION

As an increasing number of tribes take over their own health care programs under P.L. 638, it is critical that IHS develop management and evaluation tools to ensure accountability in these programs. In this report we have presented an example of how IHS could develop such tools. We found these factors and elements useful for assessing two CHR programs. However we recognize that IHS might develop others as well, and we encourage them to develop their own system to monitor and measure the CHR program.

This study shows that these factors and elements are indeed useful as a basis for gauging CHR program effectiveness. They are, in effect, common denominators for all 260 CHR programs. If used flexibly and with common sense, they will demonstrate many things about how, and how well, a program is functioning. We think they are particularly valid because they came from a wide variety of people who know about, and are involved in, the CHR program.

We learned a number of valuable lessons about the factors and elements:

The factors and elements are interrelated. Respondents named some elements in connection with more than one factor. For example, they named "the existence of a tribal health care plan" as an element for Factors 1, 2, and 3. They named "consumer support/satisfaction" for Factors 1 and 2. Or, sometimes one of the factors is also an element for another factor. For example, "do CHRs work closely with the tribe's health care system," which is Factor 2 (Integration), is one of the elements for Factor 1 (Agreement on the Role). Thus one element may shed light on a number of factors. Also, no single factor or element can tell the whole story of how a program functions.

The elements must be applied flexibly. Elements should not be viewed rigidly or used in a "cookbook" manner. Depending on the program, some elements may be more useful than others and some may not make sense at all. Interpreting information must also be done flexibly. For example, the fact that a tribe uses a variety of management tools does not necessarily mean, in and of itself, that the program is well managed. Or, the fact that a CHR coordinator is "part-time" does not necessarily mean that a program gets less support from IHS than from a full-time coordinator.

Observation is a critical part of applying the elements. We found that observation helped us to identify issues that we could not find directly when looking for the elements. For example, one of the most substantial conclusions we made about these two programs was that they are primarily transportation programs. Yet none of the elements

specifically focuses on the issue of transportation. We only learned that these were transportation programs through observing, spending time with CHRs, and holding numerous conversations with people at both the local and area levels.

COMMENTS

The Assistant Secretary for Planning and Evaluation (ASPE) and PHS commented on the report. The full text of their comments is in Appendix B.

The ASPE agreed with us that that more attention should be paid to the CHR program and that our report provides IHS with an approach to move in this direction.

The PHS concurred with the findings and recommendation in our companion report entitled "Management Issues in the Community Health Representative Program." They described steps that IHS has initiated to revitalize the program and noted that their revitalization strategy will take into account the factors described in this report.

We thank ASPE and PHS for their comments.

APPENDIX A

ENDNOTES

1. Indian Health Manual, 3-16.2B

2. Indian Health Manual, 3-16.13C

3. This is a potentially controversial issue. Some respondents expressed concern about CHR access to medical records and patient confidentiality. One suggested allowing limited access.

APPENDIX B

AGENCY COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Memorandum

Date MAR 24 1993

From Acting Assistant Secretary for Health

Subject Office of Inspector General (OIG) Draft Reports "Management Issues in the Community Health Representative (CHR) Program," and "Revitalizing the CHR Program"

To Acting Inspector General, OS

Attached are the Public Health Service comments on the subject draft reports. We concur with the recommendation to thoroughly re-examine the CHR program and determine its future direction. The Indian Health Service has begun activities to revitalize the program. The attached comments discuss the actions planned or taken to develop a national strategy to revitalize the CHR program.

Audrey F. Manley

Audrey F. Manley, M.D., M.P.H.

Attachment

PUBLIC HEALTH SERVICE (PHS) COMMENTS ON THE OFFICE OF INSPECTOR GENERAL (OIG) DRAFT REPORTS "MANAGEMENT ISSUES IN THE COMMUNITY HEALTH REPRESENTATIVE PROGRAM," OEI-05-91-01071, AND "REVITALIZING THE COMMUNITY HEALTH REPRESENTATIVE PROGRAM," OEI-05-91-01070

General Comments

The OIG reports on the Community Health Representative (CHR) program provide valuable information. They highlight problems that the Indian Health Service (IHS) is aware of and is working actively to resolve. The reports also supported PHS efforts to implement long-range initiatives in collaboration with the IHS Headquarters East and the Tucson-based Office of Health Programs Research and Development.

The IHS, in order to determine if Area Office CHR programs are meeting the intent of Congress and program objectives, will utilize an evaluation methodology developed by the Oklahoma City Area Office. The Oklahoma Area Office's CHR annual program assessment is comprised of a standardized table of scores that are derived from a comparison of the scope of work and data in the CHR Information System II (CHRIS II) records. Using this methodology, the Oklahoma Area Office has performed annual evaluations to compare the progress of individual CHR programs between Fiscal Years (FY) 1990 and 1991. Because of the satisfactory results obtained in the Oklahoma Area Office, a version of this management tool will be distributed to the other Area Offices.

In addition, IHS is developing outcome and quality oriented evaluations for the CHR program. The evaluations will be based on "Healthy People 2000" objectives, the patient care component of the Resource and Patient Management System, and data contained in CHRIS II.

OIG Recommendation

The PHS, together with Tribes, should thoroughly re-examine the CHR program to determine its future direction. If a consensus is reached to revise the program, PHS should develop the appropriate legislative proposals to do so. If it remains as a broad-based health care program, PHS should develop a multifaceted national strategy to revitalize the CHR program.

PHS Comments

We concur and will initiate actions to revitalize the program. IHS has begun activities in this regard. The Area Office CHR Coordinators met with IHS Headquarters staff the week of October 26, 1992, and drafted an action plan to revitalize the

CHR program. This draft action plan was presented to the Board of Directors of the National Association of CHRs. The purposes of this presentation were to (1) brief Board members on the goals and objectives of the draft action plan, and (2) seek Board member comments on, criticisms of, and suggested improvements to the draft action plan.

The IHS' FY 1993 activities to revitalize the CHR program will culminate in a national IHS/CHR Tribal Partnership Conference which is tentatively scheduled for late September 1993. It is expected that this conference will be attended by IHS executives and managers, tribal leaders, CHRs, and consumers. At this conference, IHS intends to summarize the findings and recommendations contained in the OIG reports. Position papers on the "national goal and objectives of the CHR program" and "role of the CHR" will be presented also.

In developing a national strategy for revitalizing the CHR program, IHS will carefully consider the factors, identified in the OIG reports, that influence the effectiveness of CHR programs. IHS acknowledges that:

- The role of the CHR must be well-defined and understood by tribal governments, community members, and the IHS health care team.

- A community-based health care outreach program should work closely with the health care professionals serving the respective communities. Therefore, CHRs must be integrated into the health care system.

- The CHR program is a community-based, tribally-operated program that can only be effective with full tribal support and direction.

- IHS support and direction is important to make a strong CHR program.

The national strategy will address the factors mentioned above.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 2020

DEC 1 1992

TO: Bryan B. Mitchell
Principal Deputy Inspector General

FROM: Assistant Secretary for
Planning and Evaluation

SUBJECT: OIG Draft Reports: Management Issues in the Community Health Representative Program," OEI-05-01071 and "Revitalizing the Community Health Representative Program," OEI-05-91-01070

The draft reports on the IHS Community Health Representative Program present compelling evidence that more attention should be paid to this program. Your findings are dramatic and the proposed elements of a revitalization strategy provide a thoughtful framework for further action. The clearest indication that the program could be strengthened is the finding that the majority of local respondents are not familiar with its goals and objectives. Your examination of the SOW and CHRIS II reports calls into question the usefulness of these instruments as management tools. In addition, the lack of integration of CHRs into Native American primary care systems is particularly problematic. This report provides IHS with an approach to begin examination of the program.

We have the following specific comments.

- The reports document that transportation is an important component of CHR responsibilities. There exist large, unexplained discrepancies, however, between different sources of information on the proportion of the CHR's time which is devoted to transportation services. It is not clear that revision of the program to become primarily a transport program is actually a reasonable option to be considered by IHS, based on these preliminary findings.

- "Tribal support and direction" is listed as one of the four key factors influencing CHR program effectiveness. However, as noted on page 4 of the "Management Issues" report, only one of 15 surveyed tribal members responded to IHS inquiries. This report would be strengthened by an increased effort to include tribal input as an integral component of your evaluative process.

- It would be helpful to clarify how information was gathered from the 403 respondents. When you "talked to" respondents, was a questionnaire used, or were these free flowing conversations? Was a standard set of questions used to base the contacts?

- How were the four factors that most influence the effectiveness of CHR programs developed? Were respondents presented with a list of factors created by your staff? Were they elicited through focus groups? Many perspectives were represented in the comments: a statistical breakdown of the commentary would clarify the agreement on various elements and assertions.

- The organization of the papers is somewhat confusing. It is not clear which report should be read first, and the reader often finds it necessary to consult one document in order to fully understand some of the points made in the other. It might be preferable to consolidate the reports into a single document, with the methods, findings and recommendations clearly organized.

- Your case studies indicate that the information presented in written documents was sometimes contradicted by your observations. Did you ask any of the respondents to address the apparent discrepancy between the written materials and your observations on elements A and D of Factor 1?

- References to the presence or absence of tribal health plans in the "Revitalizing" report are confusing and should be clarified. The discussion of Factor 2, Element D, on page 10 states that "as mentioned under Factor 1, Element A, we found no plan." The referenced section on Factor 1, Element A does not mention this finding, however, and even states on page 7 that "Both sites were rich in documentation." In the summary section following the individual discussions of the elements, at the bottom of page 8, there is also an indirect reference to "the absence of documents (like a tribal health plan)."

Martin H. Gerry